HERITAGE VALLEY FAMILY PRACTICE

PATIENT INFORMATION SHEET (ADOLESCENT TO AGE 18)

Please answer these questions concerning the patient's health status. This general information will help our doctors take better care of you. Of course, all information is confidential.

Date: _____

Chart # _____

Patient's Name _____ Birth Date _____

Mother's Name _____ Father's Name _____ Home Phone _____

Who lives in your household? _____

Are they in good health? _____

Health Habits

(Fill in boxes of those that apply)

Do you??

YES	NO	
☐	☐	Use tobacco?
☐	☐	Drink any alcohol?
☐	☐	Use any recreational drugs?
☐	☐	Or anyone in your house have a gun?
☐	☐	Have a smoke alarm at home?
☐	☐	Exercise regularly?
☐	☐	Wear seat belts regularly?
☐	☐	Are you sexually active?
☐	☐	Wear safety helmets?

Allergies to Medications

List any drug allergies and type of reaction ☐ None

Current Medications

☐ None

Medical / Surgical History

List all Physicians patient has seen in the last 5 years.

What current or past illness has the patient been treated for? (Please include surgeries)

PLEASE ALSO ANSWER QUESTIONS ON REVERSE SIDE

Study of Systems (Fill in boxes of those that apply)

Are there any problems with:

- ☐ Bleeding Disorder
- ☐ General Weakness
- ☐ Difficulty with Vision
- ☐ Difficulty Hearing
- ☐ Mouth or Dental Problems
- ☐ Severe Headaches
- ☐ Changing Moles
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Acne
- ☐ Handicap
- ☐ Often Depressed
- ☐ Heart Murmur
- ☐ Frequent Cough
- ☐ Change in Weight
- ☐ Change in Appetite
- ☐ Indigestion/Heartburn
- ☐ Nausea/Vomiting
- ☐ Bowel Habit Change
- ☐ Asthma/Wheezing
- ☐ Urine Incontinence or Leakage
- ☐ Joint Pains
- ☐ Cry Easily
- ☐ Overly Anxious
- ☐ Any Sexual Concerns

WOMEN

Last Menstrual Period _____

Number of Child Births/Pregnancies 1

Have you had a Pap Smear _____ (DATE)

Are you using Birth Control? _____ (YES/NO)

If so, what kind? _____

- ☐ Breast Lump or Nipple Discharge
- ☐ Vaginal Discharge or Itch
- ☐ Diabetes during Pregnancy

MEN

- ☐ Lump or Swelling in Testicle
- ☐ Penis Discharge

Are you using Birth Control? _____ (YES/NO)

If so, what kind? _____

Immunization History

Have you had:

YES	NO		YEAR
☐	☐	Tetanus Vaccine within 10 years	_____
☐	☐	Hepatitis B Vaccine Series	_____
☐	☐	Second MMR Shot	_____
☐	☐	Chicken Pox	_____

Family Health History

Do these problems run in your family?

YES	NO	
☐	☐	Alcoholism
☐	☐	Depression
☐	☐	Inherited Diseases

If yes, specify _____

Medical authorities agree that AIDS can be transmitted by:

- — receiving a blood transfusion involving infected blood
- — sharing of intravenous drug needles with an infected person
- — engaging in sexual intercourse with a person who is, or who has had sexual intercourse with, a prostitute, a bisexual/homosexual, an IV drug abuser or a hemophiliac.

	YES	NO
Do you believe you are at risk for AIDS?	☐	☐
Do you desire more information?	☐	☐
Do you desire to be tested?	☐	☐

Patient Name: _____ Date of Birth: ____/____/____

Females:
Have you ever been pregnant: [ ] Yes [ ] No
# of pregnancies: _____ # of live births: _____ # of miscarriages: _____ # of abortions: _____

Date of last pap smear: ____/____/____ Date of last mammogram: ____/____/____
Date of last Dexa (bone density) scan: ____/____/____
Type of birth control: _____ If none, would you like to discuss options today: [ ] Yes [ ] No

FAMILY HISTORY

Medical Condition	Mother	Father	Sibling	Maternal Grand-mother	Maternal Grand-father	Paternal Grand-mother	Paternal Grand-father
Anemia (Low Blood Count)							
Asthma							
Autoimmune Disease (Lupus, Rheumatoid Arthritis)							
Bleeding Disorder							
Cancer (List types)							
Clotting Disorder (DVT, PE)							
Congestive Heart Failure							
COPD/Emphysema							
Diabetes							
Gastrointestinal Disorders (Crohn's, Ulcerative Colitis)							
Genetic Disorders							
Heart Attack							
High Blood Pressure							
High Cholesterol							
Kidney Disease							
Liver Disease (Hepatitis, Cirrhosis)							
Mental Health Conditions (Depression, Anxiety, Suicide, Alcohol/Drug Addiction)							
Neurological Disorder (Epilepsy, MS, ALS)							
Osteoporosis							
Stroke							
Thyroid Disorder							

Heritage Valley Health System

____ Heritage Valley Medical Group ____ Heritage Valley Pediatric ____ Tri State OB/GYN

PATIENT INFORMATION

NAME: LAST | FIRST | MIDDLE INITIAL | SEX M F | BIRTHDATE

ADDRESS: STREET | CITY | STATE | ZIP | TELEPHONE # ( ) | MARITAL STATUS S M W Sep Div

SOCIAL SECURITY # | E-MAIL ADDRESS | **RACE** (CIRCLE ONE) American/AK Indian; Black/African American Asian/Pacific Islander; White Unknown/ Decline | **ETHNICITY** (CIRCLE ONE) Not of Hispanic Origin Hispanic Origin Unknown/ Decline | OCCUPATION (CIRCLE ONE) FT PT RET Not Employed

CELL# | ALTERNATE#

EMPLOYER OR NAME OF SCHOOL | ADDRESS | TELEPHONE # ( ) | ARE YOU A STUDENT? Yes No Part time Full time

SPOUSE, PARENT OR GUARDIAN INFORMATION *(If under 18, name of parent with whom you reside)*

NAME: LAST | FIRST | MIDDLE INITIAL | SEX M F | BIRTHDATE

ADDRESS: STREET | CITY | STATE | ZIP | TELEPHONE # ( ) | RELATIONSHIP TO PATIENT Spouse Parent Other

SOCIAL SECURITY # | EMPLOYER NAME AND ADDRESS | EMPLOYER TELEPHONE # ( )

INSURANCE INFORMATION ****PLEASE HAVE CARDS READY FOR STAFF TO COPY****

NAME OF **PRIMARY INSURANCE CO.**

INSURED'S NAME (**Subscriber of insurance**) | SUBSCRIBER'S BIRTHDATE

HOLDER'S RELATIONSHIP TO PATIENT: Circle one
Self Spouse Natural Child with financial responsibility Step Child
Natural Child without financial responsibility Adopted Child
Foster Child
Significant Other Life Partner Grandchild Organ donor

ID # OR AGREEMENT # | GROUP # | EFFECTIVE DATE

AMOUNT OF CO-PAY FOR OFFICE VISITS and SPECIALIST'S VISITS:

NAME OF **SECONDARY INSURANCE CO**

INSURED'S NAME (**Subscriber of insurance**) | SUBSRIBER'S BIRTHDATE

HOLDER'S RELATIONSHIP TO PATIENT: Circle one
Self Spouse Natural Child with financial responsibility Step Child
Natural Child without financial responsibility Adopted Child
Foster Child
Significant Other Life Partner Grandchild Organ donor

ID # OR AGREEMENT # | GROUP # | EFFECTIVE DATE

DO YOU HAVE OTHER INSURANCE THAT WILL PAY THIS ACCOUNT?
You are required to complete an additional form.

o Automobile o Other _____
o Workmen's Comp o None

Will patient be best served in a language other than spoken English? : ° No ° Yes If yes, please specify_____

EMERGENCY CONTACT

PLEASE NAME A PERSON *WHO DOES NOT LIVE WITH YOU* TO CONTACT IN CASE OF AN EMERGENCY OR IN THE EVENT WE ARE UNABLE TO REACH YOU.

NAME / RELATIONSHIP: | TELEPHONE # - HOME ( ) | TELEPHONE # - WORK ( )

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to either: **Heritage Valley Medical Group/ Tri State Pediatric Group/ Tri State OB/GYN/ as noted above.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED: _____ DATE: _____
PATIENT OR RESPONSIBLE PARTY

TURN OVER TO NEXT PAGE

PATIENT NAME: _____ D.O.B._____

ASSIGNMENT OF BENEFITS

MEDICARE PATIENTS:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of the provider of service and/or supplier for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related service.

We do accept Medicare assignment, however, you are responsible for your Medicare deductible. Many co-insurance plans do not cover the Medicare deductible and you will be billed. It is your responsibility to know if your co-insurance does not cover this. In addition, if the 20% after Medicare is not paid by your co-insurance, it is your responsibility to contact them regarding this. Please note: we will file your co-insurance one time only.

I have read the above and fully understand my financial obligation.

_____ _____ _____

Date Patient Signature HIC #

MEDIGAP PATIENTS:

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the name of the provider of service and/or supplier for any services furnished to me by that provider of service and/or supplier. I authorize any holder of Medicare information about me to release to _____ (Name of Medigap insurer) and its agents any information needed to determine these benefits payable for related service.

I have read the above and fully understand my financial obligation.

_____ _____ _____

Date Patient Signature HIC #

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o **BLUE SHIELD PATIENTS**
We participate in a variety of Pennsylvania Blue Shield plans in addition to Blue Shield plans of other states. You will be billed for any applicable co-payments and deductibles. **I understand that payment for office visits is due in full at the time of the visit.**

o **COMMERCIAL HEALTH INSURANCE PATIENTS**
As a courtesy to our patients, when we have your complete insurance information, a claim is automatically submitted to your insurance carrier unless we are instructed otherwise. In some cases, you will receive payment. You are personally responsible for payment of the entire account. We will assist you; however, any questions related to delayed payment or denial should be directed to your insurance company and not to our office.

o **HMO AND PPO PATIENTS**
We participate in numerous HMO and PPO programs. Due to the varied guidelines defined by each plan, it is your responsibility to know your specific plan. Additionally, in certain programs, you will be responsible for any co-payments that apply.

o **SELF PAY PATIENTS**
Payment for services rendered is due at the time of service unless other arrangements have been made prior to your appointment. Your prompt payment is appreciated. We do not want your health care to be a financial hardship to you. If you have any difficulties, our billing department will help to establish a payment program to accommodate your needs.

I have read the item checked above and fully understand my financial obligation.

_____ _____

Date Patient Signature

Heritage Valley Medical Group

AUTHORIZATION FOR THE TREAMENT OF A MINOR

Patient Name: _____ Date of Birth _____/_____/_____

I (we) consent to any necessary examination, anesthetic, medical or surgical treatment and/or hospital care to be rendered to the above named minor under the supervision and on the advice of a duly licensed physician during the period of my (our) absence. This form gives my legal consent for treatment.

Parent/Legal Guardian: _____ Date _____/_____/_____

Parent/Legal Guardian: _____ Date _____/_____/_____

The following individuals have my/our permission to bring the above named child to the physician's office for Well Child Exams, Immunizations, Allergy Injections, or any treatments deemed necessary by the physician after evaluation of the child.

Name of Individual	Relationship
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Any additions or deletions of this form are the sole responsibility of the parent.

Thank you.

HVMG Primary Care West
Dr. Bradley Heiple, D.O. | Dr. Melissa Rau, M.D. | Dr. Kehkeshan Shah, M.D.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

By my signature below, I herby authorize the practice to disclose my Protected Health Information (PHI) (Including my HIV/Aids related information, if any) to the person(s) listed below.

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Patient Signature: _____ Date: _____

By signing below, I herby authorize the practice to leave my Protected Health Information (including test results, prescriptions and appointment reminders) on the following:

_____ Answering Machine/Voice Mail (_____)_____

_____ E-mail _____

_____ Fax (_____)_____

Patient Signature: _____ Date: _____
(In effect until further notice from patient)

NOTE: As your primary physician, we will forward any patient information to other medical professionals/hospitals when needed in order to aid in the continuity of your care.

PLEASE LEAVE COMPLETE FORM AT THE FRONT DESK BEFORE LEAVING

Uniquely connected. For life.℠
HERITAGE VALLEY
Health System

AUTHORIZATION FOR RELEASE OF INFORMATION TO BE SENT TO OUR PRACTICE

(Please print clearly)

PATIENT INFORMATION:

Name: First_____ Middle_____ Last_____

Social security number_____ Date of birth_____

I THE UNDERSIGNED, HEREBY AUTHORIZE:

Fax #_____

Practice or Doctor's Name:_____ Phone #_____

Address: Street_____ City_____ State_____ Zip_____

TO PROVIDE: *HVMG Primary Care West*

Dr. Bradley Heiple, D.O. Dr. Melissa Rau, M.D. Dr. Kehkeshan Shah, M.D.
2201 Park Manor Blvd, Pittsburgh, PA 15205
Phone: 724-773-5890 Fax: 724-773-5892

WITH THE FOLLOWING INFORMATION:

☐ **Medical Records Summary** (includes doctors' notes, hospital records, laboratory and diagnostic tests within past two years, medication list, problem list, most recent EKG, immunization record, and living will/advance directives). If records are being sent for a specialist consultation, the most pertinent records will be sent.

☐ *Other*_____ For dates of service: from_____ to_____

PURPOSE OF DISCLOSURE: ☐ I am transferring to this practice ☐ Other_____

Expressed Authorization: ******Signature Required******

I understand that my medical record may contain information related to:

- ***Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV***
- ***Psychiatric Care***
- ***Treatment for alcohol and/or drug abuse.***

☐ I give my consent for release of this information: _____
Signature Date

☐ I **DO NOT** give consent for release of this information: _____
Signature Date

This authorization for release of information is valid for 90 days from the date of signature, unless revoked by written notice to the providing institution, provided the notice is received prior to the release of information. I understand that signing this authorization is voluntary, and Heritage Valley Health System cannot deny me treatment for not agreeing to sign this authorization. I understand that I may see a copy of the information described on this form and that there may be a fee associated with copying. I understand that once the above information is disclosed, it may not be under control of Heritage Valley Health System and may not be protected by federal privacy regulations, therefore there is a potential for unauthorized re-disclosure. I understand that this authorization may be revoked at anytime. I understand that if I do revoke the authorization, I must do so in writing and present my written revocation to be filed in my medical record, which will not apply to information that has already been disclosed in response to this authorization. *If I have questions about the disclosure of my health information, I may contact the Office Manager or the Privacy Officer of Heritage Valley Health System.* I hereby certify that I have read this authorization and agree to its terms.

_____
Required: Signature of Patient Date

_____
*Signature if other than patient **(use P.O.A. documentation)** Relationship Date

_____
Signature of witness Date

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HERITAGE VALLEY
HEALTH SYSTEM

HERITAGE VALLEY HEALTH SYSTEM
CORPORATE COMPLIANCE PROGRAM
Receipt of Notice of Privacy Practices
Acknowledgement Statement

I acknowledge I have received a copy of Heritage Valley Health Systems Notice of Privacy Practices for Protected Health Information.

_____

Patient Name *(please print)*

_____

Patient Signature

_____

Date

_____

In the event of the patients emergency condition, signature of person receiving Notice for patient.

****

*****FOR OFFICE USE ONLY**
COMMENTS

_____

_____

_____

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HERITAGE VALLEY HEALTH SYSTEM

Heritage Valley Health System
Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.

Heritage Valley Health System (HVHS) CONTINUES TO BE COMMITTED TO PROTECTING THE PRIVACY OF YOUR MEDICAL AND BUSINESS INFORMATION. It has been our practice not to disclose your medical information for any purpose without your written authorization. We are now required by law to provide you with this statement to inform you in writing how your medical information will be used and disclosed.

Protected Health Information, or PHI, is defined by the federal government as, individually identifiable health information that is or has been electronically maintained, electronically transmitted by a covered entity, or information when it takes any other form. PHI is a part of health information, including demographic information, collected from the individual and is created or received by a healthcare provider, relates to past, present, or future health or condition of the individual or payment for the provision of care. PHI identifies the individual directly or affords that the individual can reasonably be identified. Covered entity is defined as a healthcare provider who transmits any health information in electronic form.

We are required by law to maintain the privacy of your protected health information and to provide you with this Notice of our legal duties and privacy practices. HVHS is required by law to follow the terms of this Notice. HVHS reserves the right to change the terms of the Notice and to make any revision necessary to the protected health information we maintain. Once given, you may revoke your authorization in writing at any time. Other uses and disclosures not described in the Notice will not be made without your authorization.

Following any revisions made to this Notice, HVHS will make these changes available through distribution of the revised Notice by posting the revised Notice in HVHS facilities and on the HVHS website.

How your Medical Information May Be Used and Disclosed:

- HVHS will use your medical information as part of providing patient care. For example, your medical information will be used by the healthcare professionals providing your care, by the business office to bill for the services provided, and by selected care and quality employees who review medical information to assure quality and medical necessity of services provided.
- HVHS may contact you to provide appointment reminders or information about treatments, alternatives, or other health-related benefits and services that may be of interest to you.
- During inpatient treatment at a HVHS facility, the hospitals and consulting physicians are considered an Organized Health Care Arrangement (OHCA). This means related health information can be shared for purposes of treatment, payment, or healthcare operations.
- Unless you object, while an inpatient or outpatient of HVHS, and with the exception of behavioral health patients, HVHS:
  - will include general information, including your name, location in the hospital, your condition described in general terms, and your religious affiliation in a list or directory of individuals located in the facility where you are hospitalized. This information, except for the religious affiliation, will be released to people who ask for you by name. Your religious affiliation may be given to members of the clergy, even if they do not ask for you by name.
  - disclose to family members, other relatives or close personal friends who are responsible for your care the medical information directly relevant to that person's involvement with your care.
  - use or disclose your medical information to notify a family member or personal representative of your location, general condition, or death.
- HVHS may also:
  - disclose your medical information to a public or private entity for the purpose of coordinating with that entity to assist in disaster relief efforts.
  - use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events, and the conduct of public health surveillance, investigation, and intervention.

- disclose medical information when requested by a licensed state or federal agency for accreditation purposes.
- disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and /or legal proceedings.
- disclose your medical information in the course of certain judicial or administrative proceedings.
- disclose your medical information for law enforcement purposes or other specialized government functions.
- disclose your medical information to a coroner, medical examiner, or a funeral director.
- if you are an organ donor, disclose your medical information to an organ donation and procurement organization.
- use or disclose your medical information for certain research purposes.
- use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or the public.
- disclose your medical information as authorized by laws relating to worker's compensation or similar programs.
- may contact you to raise funds for the hospital.

Your Rights Regarding Your Medical Information:

Your rights related to your medical information are as follows:

- You have the right to request restrictions on certain uses and disclosure of your medical information. HVHS is not required by law to agree to your requested restrictions except when disclosure is to a health plan for services paid exclusively by the patient.
- You have the right to receive communications from HVHS in a confidential manner.
- Your have the right to inspect and obtain a copy of your medical information. This right is subject to certain specific exceptions. You will be charged a fee for any copies of your medical information.
- You have the right to request an amendment to your medical information. HVHS may deny your request for certain specific reasons. If HVHS denies your request a written explanation for the denial and information on further rights will be provided to you.
- You have the right to receive an accounting of the disclosures of your medical information made by HVHS for six years prior to your request, effective after April 14, 2003. By law, disclosures for treatment, payment, health care operations, and certain other specific disclosures are not included in the accounting.
- If you do not wish to be contacted for fundraising efforts, you may notify us in one of three ways.
  In writing: Heritage Valley Health Systems Foundations, 420 Rouser Road, Suite 102, Moon Township, PA., 15108
  By calling: 412-749-7121
  Or e-mailing: foundation@hvhs.org
- You have the right to receive a paper copy of HVHS' Notice of Privacy Practices for Protected Health Information. You have a right to submit a complaint to HVHS and/or to the United States Department of Health and Human Services if you believe HVHS has violated your privacy rights. To complain to HVHS or to request additional information on your privacy rights, please contact HVHS' Privacy Officer by calling (724) 773-3473 or by writing to HVHS Privacy Officer, Heritage Valley Health System, 1000 Dutch Ridge Road, Beaver, PA, 15009. If you choose to file a complaint you will not be retaliated against in any way.
- Per the federal Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification final rule published January 25, 2013, unless a specific exception as identified in 45 CFR 160 or 164 exists, you have a right to be notified of any unauthorized access, use or disclosure of your medical or business information which compromises the security or privacy of such information.

Your Medical Information and Health Information Exchanges (HIE):

HVHS participates in Health Information Exchanges (HIE). Generally, a HIE is an organization that regional hospitals, physicians, and other healthcare providers participate in to exchange patient information in order to facilitate health care, avoid duplication of services (such as tests) and to reduce the likelihood that medical error will occur. By participating in the HIE, HVHS may share your health information with other providers or participants of other health information exchanges, by example P3N (Pennsylvania Patient & Provider

Network) and Healtheway (a national network that allows providers to exchange information). This health information could include, but is not limited to:

- Test Results. By example, the following tests and results: laboratory including microbiology; pathology; radiology/diagnostic imaging; GI; cardiac; neurological.
- Health Maintenance documentation
- Problem list documentation
- Allergy list documentation
- Immunization profiles
- Medication lists
- Progress notes
- Consultation notes
- Discharge instructions
- Inpatient operative reports
- Emergency Room visit discharge summary note
- Urgent Care visit progress notes
- Clinical Claims Information

Ancillary healthcare related services providers may include, but are not limited to:

- Organ Procurement
- Diagnostic Testing
- Pharmacies
- Durable Medical Equipment Suppliers
- Home Health Services

All Participating Providers have agreed to a set of standards relating to its access, sharing, use and disclosure of health information available through the HIE. These standards are intended to comply with all applicable state and federal laws. As a result, you understand and agree that unless you notify your healthcare Provider that you do not wish for your health information to be available through the HIE ("Opt-Out"):

• Health information that results from any Participating Provider providing services to you will be made available through the HIE. For clarity, if you Opt-Out, your health information will no longer be accessible through the HIE. However, your opt-out does not affect health information that was disclosed through the HIE prior to the time that you opted out;

• Regardless of whether you choose to opt-out of the HIE, your health information will still be provided to the HIE. However, if you choose to Opt-Out, the HIE will not exchange your health information with other providers. Additionally, you cannot choose to have only certain providers access your health information;

• All Participating Providers who provide services to you will have the ability to access to your information. However, Participating Providers that do not provide services to you will not have access to your information;

• Information available through the HIE may be provided to others as necessary for referral, consultation, treatment and/or the provision of other treatment-related healthcare services to you. This includes providers, pharmacies, laboratories, etc.

• Your information may be disclosed for payment related activities associated with your treatment by a Participating Provider; and your information may be used for healthcare operations related activities by Participating Providers.

• You may Opt-Out at any time by requesting an Opt-Out form from the registration staff at your point of service or in one of two ways.

In writing: Heritage Valley Health System, Medical Records – Release of Information, 1000 Dutch Ridge Road, Beaver, PA 15009

By emailing: roi@hvhs.org

Please allow (2) business days for the processing of your Opt-Out request.

A list of HIE Participating Providers may be found at: www.heritagevalley.org/hie

This Notice is effective as of April 1, 2003. Revisions: 8/2008; 6/2012, 9/2013, 12/2015

As of July 01, 2017

All test results completed at a Heritage Valley Facility will be communicated through Heritage Valley's secure patient portal, **Health Link**.

Also, prescription refills should be requested through Health Link or your pharmacist.

You can sign up online at www.heritagevalley.org

If you need assistance registering for this service or have questions about this, please see our staff or email healthlink@hvhs.org

Thank you for your patience with this, as improving communication is our goal!